**Repeat Prescription Request Form**

When ordering a repeat prescription we require a **written request,** using the form below, in order to ensure accuracy, safety and efficiency. This form may be returned to us by email, fax, post, or in person at reception. We will provide repeat prescriptions of those medications which you have previously received from us, and for which you have regular annual or other review with a Doctor here at Harrow Heath Care Centre.

The name of the drug, the dose and how often to take it are marked on the label of your medication. Please tell us the quantity required and the length of time you wish it to cover.

Repeat prescriptions may incur a fee. For details please see below and our website.

Please complete the request **fully in CAPITALS** to avoid queries and delay.

|  |  |
| --- | --- |
| **Full Name:** |  |
| **Address:** |  |
| **Date of Birth:** |  |
| **Telephone number for queries:** |  |
| **Email Address:** |  |

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| --- | --- | --- | --- | --- |
| **NAME** | **DOSE / STRENGTH e.g. mg** | **How often to be taken**  | **QUANTITY of Tablets or mls of liquid** | **LENGTH OF TIME prescription to last.** |
| *Example: IBRUPROFEN* | *200MG* | *3 TIMES A DAY*  | *50 TABLETS* | *2 MONTHS* |
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Members may request a repeat prescription to be dispensed at Clementine Churchill Pharmacy, or to be collected from reception at Harrow Health Care Centre for no charge.

**Members requesting a repeat prescription which is to be sent out to them, or faxed to their designated pharmacy, will be charged an administrative fee.**

Non-members repeat prescriptions are not generally provided except in certain circumstances when this has been pre-arranged for which there will be a professional and administrative charge.

 *Please tick one box below that applies as to how you wish to receive your prescription:*

[ ]  Collect medication from Clementine Hospital Pharmacy (Please allow 72 hrs. / 3 working days)

 [ ]  Collect Prescription at HHCC reception to be filled elsewhere

[ ]  Post prescription to you (fees payable)

[ ]  Fax prescription to your chosen pharmacy (Fax number……………………………………………………) (fees payable)

Signed…………………………………………………………… Date.....................................

*Please note that most pharmacies will only accept a faxed prescription if directly faxed from us to them*